



Patient's Full Name and Previous Names Used	/ / Date of Birth	Medical Record Number
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Street Address	City	State	Zip Code
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DESCRIPTION OF INFORMATION TO BE DISCLOSED.

Information to be Released – Check all that apply:	
<input type="checkbox"/> Pertinent Health Information <small>(All clinical information for the last 2 years, includes radiology and laboratory reports, does not include images)</small>	<input type="checkbox"/> Entire Health Record <small>(Includes all electronic and paper documentation including non-clinical in the patient's record, does not include images, charges may apply)</small>
<input type="checkbox"/> Outpatient Clinic, Inpatient or ER visit for the following date or date range: _____	<input type="checkbox"/> Images: (include date range requested) Radiology: _____ Cardiology: _____ Neurology: _____ Other: _____
<input type="checkbox"/> History & Physical Only	<input type="checkbox"/> Alcohol & Drug Information or HIV Test Results (circle one or both)
<input type="checkbox"/> Visit List Only	
<input type="checkbox"/> Immunization Records Only	
<input type="checkbox"/> Other: Please list exact documents and/or date range needed: _____	

TO WHOM DISCLOSURE IS BEING MADE

Send Information to the Following – Please complete all fields:			
Organization:	Telephone:		
Attention:	Fax Number:		
Email Address:			
Street Address	City	State	Zip

PURPOSE OF RELEASE

Purpose of Release – Check and complete all that apply:
<input type="checkbox"/> Doctor appointment on (date): ____ / ____ / ____ Location: _____
<input type="checkbox"/> Other ongoing treatment or care: _____
<input type="checkbox"/> Other: _____

METHOD OF DISCLOSURE/RELEASE INFORMATION BY

<input type="checkbox"/> Mail delivery	<input type="checkbox"/> Pick up	<input type="checkbox"/> CD/DVD, if available	<input type="checkbox"/> Encrypted Email, if available <small>size and restrictions apply</small>
<input type="checkbox"/> Fax	<input type="checkbox"/> Verbal Communication	<input type="checkbox"/> Cloud Images	<input type="checkbox"/> Unencrypted Email if available <small>size and restrictions apply. Signature required – see below</small>

REVOCACTION

I authorize the use and/or disclosure of the information specific in this authorization regarding the patient named above. I understand that I have the right to revoke this authorization at any time, except when actions have already been taken based on this authorization. To revoke this authorization, I must provide written notice to the Health Information Management department of The Children's Mercy Hospital or to the other organization named.

EXPIRATION:

Unless this authorization is revoked, it will expire:

- Once the disclosure is complete
- Once the episode of care is complete

ASSURANCE OF PAYMENT: I do not need to sign a specific authorization to disclose information for treatment, payment or health care operations. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure treatment, payment or eligibility for services at The Children's Mercy Hospital. I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protections, then such information may be re-disclosed and would no longer be considered protected. If I have questions about disclosures of my information, I can contact the Health Management department of The Children's Mercy Hospital at (816) 234-3455 or ROI@cmh.edu.

Return completed form via email to ROI@cmh.edu or fax to (816) 701-4034

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Printed Name of Patient, Parent, or Legal Guardian	Relationship to Patient	Telephone Number		
Signature of Patient, Parent, or Legal Guardian			Date	
Street Address (if different from above)	City	State	Zip Code	

If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided.

Individuals may request to receive their medical record and other protected health information (PHI), or direct the PHI to a third party, by alternative means, including without encryption. An unencrypted format is at risk for interception or access by an unintended person. Children's Mercy is not responsible for disclosure of PHI sent or stored in an unsecured manner at the individual's request, or for safeguarding the information once delivered.

Please sign below to request records in an unencrypted format. Your signature indicates that you understand and accept the risks of transmitting and storing PHI without encryption.

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Printed Name of Patient, Parent, or Legal Guardian	Relationship to Patient	Telephone Number		
Signature of Patient, Parent, or Legal Guardian			Date	

Staff Use Only

Released by _____ Date: _____

Return to HIM via email ROI@cmh.edu, fax 816-701-4034 or inter-office mail.

Copy to Individual.